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Virginia Association of Health Plans

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Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

April 4, 2012

Cindi B. Jones, Director
Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources

Re: Comments related to Essential Health Benefits

Dear Director Jones:

Thank-you for the opportunity to provide comments on the overall topic of "essential health benefits" (EHB) and the *Preliminary Analysis of Essential Health Benefits, Benefits Mandates and Benchmark Plans* (Analysis) that was prepared by PricewaterhouseCoopers and distributed in February of this year.

Kaiser Permanente believes the availability of qualified health plans through the Exchanges and the development of the "essential health benefits" and state selection of the benchmark plan are among the most critical aspects of the market reform provisions in the Patient Protection and Affordable Care Act (ACA). State selection of the benchmark plan should focus on ensuring access and affordability and reflect a strategy for improving overall quality of care and health outcomes while controlling the growth in healthcare costs.

We offer the following comments and recommendations:

General Comment on the Benefit Design of any Chosen Benchmark Plan
According to the Bulletin issued by the federal Department of Health and Human Services (HHS), the chosen benchmark will serve as the reference plan "reflecting both scope of services and any limits." Health insurance issuers can adopt the scope of services and limits of the state benchmark, or vary them within described parameters. HHS is considering allowing benefit substitution both within and across the ten categories, and has sought comments about how this might work.

When issued, the final HHS guidance regarding benefit substitution may ultimately affect the way Virginia addresses the benchmark plan. Kaiser Permanente believes that some flexibility from the benchmark plan will be important, and the appropriate type and amount of flexibility varies depending on what aspect of benefit design is involved. In terms of the enumerated benefits in the benchmark plan, consumers are better served by standardized benefits. We believe an approach that would allow insurers to limit, for example, access to maternity care and instead

provide more generous allowances for some other benefit category is ill-advised and contrary to the clear intent of the ACA that each of these services be covered. Such an approach could perpetuate many detrimental practices in today's market, where insurers are encouraged to compete on the basis of risk avoidance rather than on quality, service, and price. Moreover, such an approach would defeat the ACA's attempt to strengthen the role of consumers in the health care marketplace by arming them with greater ability to make "apples-to-apples" comparisons, based on more reliable information about quality of care.

The Commonwealth will have to determine how to address the way different plans offer differing cost-sharing elements to their customers. We support as much standardization in cost-sharing definitions as the structure of the ACA allows, for the same reasons outlined above: to prevent carriers from deploying risk selection strategies, and to give consumers the ability to make clear comparisons in a market where competition is driven as much as possible by quality, service, and price.

In contrast, in the management and administration of benefits, such as prior authorization requirements or medical necessity determinations, flexibility is important. These practices relate more to the operating models of competing health plans in delivering or arranging care for consumers than to the actual benefit package. For example, an integrated system such as Kaiser Permanente generally does not impose prior authorization requirements, relying instead on the clinical judgment of our physicians. Without such flexibility in the administration of benefits, a too-rigid interpretation of the benchmark plan could undermine the ACA's intent to foster innovative care delivery models through accountable care organizations. These entities will have little opportunity to flourish if they must fit within the confines of administrative functions that are built around the dominant financing systems that exist in the marketplace today.

Some flexibility will also be warranted for visit limitations and exclusions in the benchmark plan, to accommodate different administrative and benefit management practices among issuers. However, unfettered flexibility on the scope of benefits could also prevent consumers from getting medically necessary care and lead to risk selection strategies by some insurers. We believe that this aspect of benefit design should be subject to regulatory oversight to determine when flexibility for the scope of benefits is appropriate to accommodate the administrative/benefit management strategy or care delivery model.

Habilitative Services

There is a great deal of confusion about the term "habilitative services." This term has only recently begun appearing, and we advise caution as the Commonwealth considers these services in the benchmark plan analysis.

Virginia currently has no definition of the term. Maryland has a very narrow definition that will go into effect in October of this year, and it is limited to children with congenital or genetic birth defects. (See Maryland 2012 H.B. 1055) HHS has suggested a definition in their Bulletin, which we have provided comments on. Briefly, we believe that inclusion of "maintenance of function" in the definition is too expansive. Depending on how it is interpreted, maintenance of function could require coverage for any service intended to postpone or mitigate the effects of aging on function (e.g., coverage of reading glasses or personal trainers to maintain

musculoskeletal tone and function). The scope of mandated habilitative services should be limited to services designed to address a delay in the age-appropriate development of the function, and that an objective and evidence-informed approach to determine if progress is occurring should be required as part of the process for determining the length of time the services must be covered.

Defined too broadly, habilitative services could expand the scope of today's notion of health care so that it finances a wide range of social and educational skills. Habilitative services should only be covered when they address a specific and articulated health care goal. They should not be covered for providing respite, day care, or school services, or for addressing deficits in the skills and knowledge that are required to access an educational or academic curriculum, for vocational or employment issues, or for independent living.

The HHS Bulletin currently proposes two approaches to habilitative services. In one approach, habilitative services would be offered at parity with rehabilitative services. For instance, a plan covering services such as physical therapy, occupational therapy, and speech therapy for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation. In the second, transitional approach, plans would decide which habilitative services to cover, and would report on that coverage. HHS would evaluate those decisions and further define habilitative services in the future.

We recommended to HHS that they adopt the transitional approach. This practical approach will allow time to establish the appropriate definition and scope of services, taking into consideration medical evidence, evidence of progress based on the provision of services, affordability and access to care. We equally recommend that Virginia proceed with great caution in determining how the benchmark plan and others deal with this novel concept.

Pediatric Oral and Vision Care

The PWC Analysis notes that there is great diversity in the ways that current plans cover pediatric oral and vision care. Like habilitative services, though, the Analysis shows that these services are not routinely covered under a typical major medical plan. Because affordability is critical for small businesses and families, we are concerned that the FEDVIP benchmark for pediatric vision care is considerably more comprehensive than coverage offered in the small group market today and thus will mean cumulative increases in premium costs. For both pediatric oral care and pediatric vision care, Kaiser Permanente recommends that the benchmark plan should conform, as much as possible, to coverage in the current small-group market, as a better option to assure affordability and access to these critical services.

Pharmacy Benefits

HHS is currently considering a standard that applies the Medicare Part D model to PPACA. Under that model, plans must cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes. If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.

We are concerned that this approach may require plans with formularies that are structured differently than the benchmark's to modify their formularies to match the benchmark plan. If benchmarks shift from year to year, this will create confusion among beneficiaries and excess complexity for the plans managing drug benefits.

The fundamental objective of any drug benefit is to ensure that patients have access to the prescription drugs necessary to treat their medical conditions. Different health plans provide access to these drugs in different ways. Some health plans include many (or all) drugs on their formularies and seek to encourage the use of favored drugs through differential cost sharing, or tiered benefits. Other plans use more traditional, closed formularies and provide access to medically necessary non-formulary drugs through medical exception processes. In some cases, plans will cover (at the appropriate brand or generic, on-formulary level of cost-sharing) non-formulary drugs that the physician determines are necessary to treat a particular patient, based on his/her medical judgment that all of the available formulary drugs may not be suitable for that patient.

As we have noted in our comment letter to HHS, government should not get too deeply into the specific oversight of formulary content. The Commonwealth exercises appropriately narrow regulatory authority now outside of Part D, and we believe the Commonwealth should leave a similar amount of flexibility to market participants when considering the pharmacy benefit offered in its benchmark. If there is to be a standard, it should focus on ensuring patient access to medically necessary drugs, and it should differentiate by formulary type (open, multi-tiered, or closed with an open exception process). Plans with closed formularies that provide covered, medically necessary access to non-formulary drugs by exception without plan restrictions should not be required to match their formulary designs to a benchmark plan.

Applied Behavior Analysis

The PWC Analysis notes the potentially high cost of the mandated benefit for Applied Behavior Analysis (ABA), and observes, "There is little experience to understand the potential cost impact of this mandate." Kaiser Permanente agrees that the uncertainty here is considerable, and the breadth of this mandate must be carefully monitored and studied, both for its costs and also for its effectiveness over time.

Conclusion

We appreciate the opportunity to provide comments on this important topic. Please feel free to contact me at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions.

Sincerely,

Laurie Kuiper
Sr. Director, Government Relations
Kaiser Permanente

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April 4, 2012

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Director, Virginia Health Reform Initiative
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Submitted electronically to VHRI@governor.virginia.gov

Re: PricewaterhouseCoopers LLP Preliminary Analysis of Essential Health Benefits, Benefit Mandates and Benchmark Plans for the Virginia Health Reform Initiative

Dear Director Jones:

Thank you for the opportunity to provide comments to the Virginia Health Reform Initiative (VHRI) in response to the PricewaterhouseCoopers LLP preliminary analysis of Essential Health Benefits (EHBs), benefit mandates and benchmark-eligible plans. The analysis provides important information and suggests the need for corroboration by Virginia's health plan community on a critical decision point – the definition of the EHB package – for the Commonwealth that will influence the affordability of Health Benefit Exchange (HBE) product offerings for consumers and carriers and, ultimately, the HBE's success.

Amerigroup, which refers to both Amerigroup Corporation and Amerigroup Virginia Inc., welcomes the opportunity to share our thinking on how to design an EHB package supportive of a viable, vibrant insurance marketplace. When defining the EHB package, we believe commitment to affordability and alignment should serve as the cornerstone of the Commonwealth's consideration. To this end, we have organized our comments around the following recommendations:

- Structure the EHB package to ensure coverage affordability first and foremost
- Exclude mandated benefits and offers beyond the minimum categories
- Select a benchmark plan by June 30 and define the full package by Sept. 30, 2012
- Develop an initial selection process and annual review of mandated benefits and offers to include cost- and evidenced-based analysis for prioritizing access to affordable coverage
- Align the EHB package with Medicaid benefits, services and likely provider types as a strategy to promote continuity of care
- Supplement and/or substitute benefits within the benchmark plan by focusing on affordability of coverage and alignment with Medicaid

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Unless the benefit package is affordable, many – particularly lower-income individuals and families and former beneficiaries of government-sponsored programs, such as Medallion II (Medicaid/FAMIS Plus) and FAMIS, who comprise a disproportionate share of the future market – will be challenged to purchase insurance coverage. Further, as these individuals and their families look to the Virginia HBE in future years, seamless coverage and continuity with their previous benefit, provider and care regimes will be paramount.

As a current partner of Virginia's Medicaid managed care program, Amerigroup has first-hand experience responding to the health care needs of low-income individuals and families, especially uninsured and underinsured Virginians. Our comments, and the principles that guide them, are aimed at assuring the promise of affordable, high-quality and accessible health care – central features of Medallion II and FAMIS – is echoed in the Exchange.

Ensure Affordability – and Coverage

It is critical the design of the EHB package – regardless of the underlying benchmark plan – balances the coverage needs of Virginians with assurances for affordability to enhance the long-term success of the HBE. Design of the EHB will affect individuals and families, both eligible for subsidies and not, as well as small employers purchasing inside and outside of the Exchange. If the design is too broad or costly, individuals and small employers may not be able to afford coverage and opt to go without. For individuals and families familiar with the extremely low levels of cost sharing of government-sponsored programs, affordability is central to the coverage-purchasing decision.

The preliminary analysis by PricewaterhouseCoopers LLP illustrated this interplay between EHB design and premium rates – as did an October 2011 report by the Institute of Medicine. With this in mind, it is imperative the Commonwealth consider affordability when making decisions about EHB design.

In support of this objective, Senate Bill No. 496, the Virginia HBE Act, as sponsored by Sen. John C. Watkins, discourages the Commonwealth from automatically adding Virginia-mandated benefits and mandated offers beyond the minimum categories to the EHB package. Amerigroup commends Sen. Watkins for his needed leadership and constructive efforts to advance a state-based Exchange in Virginia during the 2012 General Assembly session. We support this reasonable approach to mandated benefits and offers as good public policy.

If the elimination of mandated benefits and offers that exist outside the 10 federally required categories is untenable, Amerigroup would recommend the Commonwealth create a process for phasing out those that are not supported by cost- and evidenced-based analysis.

Make Package Decisions Soon

We believe selection of the benchmark plan should be made as soon as is feasible, preferably by June 30, with decision on the composition of the full package by Sept. 30, 2012, to allow the necessary time for carriers to meet statutory and regulatory requirements. There are many steps to be taken and much work to complete before a carrier is able to offer a health plan; benefit design is just the first. Time is needed also for the product to receive approval from the Commonwealth and, for products sold through the Exchange, from the HBE itself. All of these steps must happen well in advance of the proposed Oct. 1, 2013, initial open enrollment period.

These processes and the time necessary remain unclear; the Virginia HBE is a new marketplace with many parameters to be determined. As a result, development and approval of initial plan offerings may take longer. Amerigroup encourages the Commonwealth to begin the selection process for a benchmark plan as soon as is feasible, with package decisions quick to follow. This is critical to ensuring carriers can develop products, meet filing deadlines and obtain approval from the Exchange within the short timeframe leading up to 2014.

In addition, this timeframe ensures the selection of a benchmark plan remains a decision driven by Virginia preferences and on-the-ground considerations. If the Commonwealth does not select a benchmark plan by the third quarter of 2012 then, according to the recently issued bulletin from the U.S. Department of Health and Human Services, the default option – the largest small group plan by enrollment – may automatically become the benchmark plan. However, as the bulletin does not specify at which point in the third quarter this default option would be triggered, it is in the best interest of the Commonwealth to make a decision sooner, by June 30, 2012.

Create a Tool for Monitoring Affordability

As Virginia evaluates and makes decisions about the EHB package now and into the future, Amerigroup believes it should consider a tool for reviewing existing benefit mandates and potential benefit mandates, particularly as it relates to the affordability of the EHB package. Whether through an initial selection process, an annual review of mandates or both, the Commonwealth should perform a cost-benefit analysis for prioritizing access to affordable coverage. Issues we recommend be addressed include:

- Scientific and medical information of the mandated benefit or offer
- Health and economic impact of the mandated benefit or offer
- Extent to which the mandated benefit or offer will increase or decrease the affordability of health insurance

Promote Continuity of Care

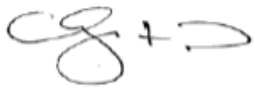
As discussed in a 2011 memorandum issued by the VHRI, the likelihood that many participating in the HBE will shift between Medallion II and FAMIS and this new marketplace is very real. Caused by relatively small fluctuations in incomes, the phenomenon of churn presents significant challenges to the Commonwealth's goals for each of these programs. Similarly, the ensuing discontinuity would likely reduce timely access to care, particularly in the most appropriate setting, potentially resulting in negative health outcomes and higher medical costs.

While Amerigroup strongly believes the Basic Health Program remains a very promising option to mitigate the impacts and sources of churn, the Commonwealth has additional tools at its disposal to promote continuity of care – including the design of the EHB package. To this end, we would encourage the Commonwealth to design the EHB package in alignment with Medicaid. The supplementation and substitution of the benchmark plan, as necessary, provides an additional opportunity to align covered benefits between these programs and should be considered carefully.

Again, Amerigroup applauds the Commonwealth for the decision to proactively meet the challenges and opportunities presented by the task of designing a state-based Exchange, especially in a manner that engages stakeholder input and expertise. We strongly believe this decision will result in a successful and sustainable Exchange marketplace that will benefit all stakeholders, most particularly the financially vulnerable and uninsured.

On behalf of Amerigroup, thank you again for the opportunity to comment on this preliminary analysis and the important issues it examines. We look forward to continuing to work with you, as the governor and the General Assembly make final decisions on the Virginia EHB package and the Exchange as a whole.

Sincerely,



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April 4, 2012

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Dear Ms. Jones:

The Virginia Association of Health Plans (VAHP) appreciates the opportunity to comment on Essential Health Benefits (EHBs) and the PricewaterhouseCoopers' Preliminary Analysis of Essential Health Benefits, Benefit Mandates, and Benchmark Plans (PwC report).

When considering a benchmark plan for the Commonwealth, policymakers should be mindful that the purpose of the Health Benefit Exchange is as a vehicle to **offer the most affordable health insurance plan to the largest number of individuals** possible. Adding additional services to those already mandated by law to be provided will have significant cost impact on those intended to be covered, making health insurance beyond reach for many.

We disagree with the PwC report's suggestion that additional benefits such as coverage for applied behavioral analysis (ABA); surgical treatment for morbid obesity; acupuncture; in-vitro fertilization; and hearing aids should be considered as covered benefits under the benchmark plan. The Virginia General Assembly has considered and rejected mandating these benefits in the individual and small group markets. In keeping with the goal to provide the most affordable coverage for the largest number of individuals, the additional benefits suggested in the report should not be added. Policymakers should keep in mind that the addition of benefits to meet the required ten EHB categories will result in increased premiums.

A discussion of the EHBs and a chart comparing the ten ACA-required coverage categories to the benefits covered and state-mandated in the largest small group plan, the Anthem Small Group PPO, is enclosed as support for selecting this plan as the benchmark plan.

On behalf of our members, VAHP appreciates consideration of our comments.

Best regards,

Doug Gray
Executive Director

Enclosures

VIRGINIA HEALTH BENEFIT EXCHANGE
ESSENTIAL HEALTH BENEFITS BENCHMARK PLAN

Section 1302 of the Patient Protection and Affordable Care Act (ACA) directs the Secretary of Health and Human Services (HHS) to define Essential Health Benefits (EHB) which will need to be offered in the individual and small group markets both inside and outside the Health Benefit Exchanges (HBE).

On December 16, 2011, HHS, through its Center for Consumer Information and Insurance Oversight (CCIIO), released an Essential Health Benefits Bulletin (Bulletin) indicating that a benchmark plan reflecting the statutory standards for EHB must be selected by each state. The choices available to the states to serve as the benchmark plan for 2014 and 2015 are:

1. the largest plan by enrollment in any of the 3 largest small group insurance products in the state's small group market;
2. any of the largest 3 state employee health benefits plans by enrollment;
3. any of the largest 3 national FEHBP plan options by enrollment; or
4. the largest insured commercial non-Medicaid HMO operating in the state.

Several Exchange bills introduced in the 2012 Regular Session of the Virginia General Assembly (HB 464-Byron; SB 488-Saslaw; and SB 496-Watkins) indicate the largest plan by enrollment in any of the 3 largest small group insurance products in the state's small group market would serve as Virginia's benchmark plan. In addition, the default plan set out in the Bulletin if a state does not chose a benchmark plan by the 3rd Quarter 2012 is the largest small group plan. As identified by CMS and the PricewaterhouseCoopers report, Virginia's largest small group plan is offered by Anthem and is a PPO product. It seems clear that Virginia is moving toward the Anthem Small Group PPO plan as the benchmark plan; an action VAHP supports.

The Bulletin and the Center for Medicare and Medicaid Services' (CMS) FAQ (FAQ) on the Bulletin (released 2/17/12) discuss the 10 coverage categories set out in the ACA which will need to be included in the benchmark plan. These are:

- Ambulatory Patient Services;
- Emergency Services;
- Hospitalization;
- Maternity and Newborn Care;
- Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment;
- Prescription Drugs;
- Rehabilitative and Habilitative Services and Devices;
- Laboratory Services;
- Preventive and Wellness Services and Chronic Disease Management; and
- Pediatric Services, including Oral and Vision Care.

The benchmark plan must include benefits set out in all 10 coverage categories delineated in the ACA. State-mandated benefits applicable to small group business enacted into law by December 31, 2011, should be considered in determining if the benchmark plan selected covers the required benefits. If Virginia mandates other benefits to be included in the qualified health plans sold in the HBE, the cost of these additional benefits for those subsidized individuals must be borne by the Commonwealth. Policymakers should keep in mind that the addition of benefits to meet the required 10 EHB categories will result in increased premiums.

The attached chart delineates the Virginia mandated benefits; how these mandates fit into the 10 ACA-required coverage categories; additional benefits offered in the benchmark plan that satisfy the requirements for coverage in categories where no Virginia mandates apply; and information on additional services that will need to be offered based on guidance from the CMS FAQ on how these services will be determined.

The default plan, the Anthem Small Group PPO plan, offers services beyond those specifically mandated by Virginia law. This plan includes pediatric dental and vision preventive services , as well as a number of other benefits, such as coverage for Durable Medical Equipment; Lab services; Preventive and Wellness services, as part of the standard benefits. It should also be noted that Virginia is consistently in the top 5 to 7 states with the highest number of insurance mandates resulting in comprehensive benefits currently being offered by the benchmark plan.

Essential Health Benefits
Virginia Benchmark Plan

Benefit Category	Applicable VA Mandate(s)	Benchmark Plan Benefits	Supplemental Benefits Needed	Suggestions/Comments
Ambulatory Patient Services	§38.2-3418.2 – Bone/Joint Coverage TMJ Procedures §38.2-3418.3 – Hemophilia & Congenital Bleeding Disorders §38.2-3418.8 – Clinical Trials for Cancer §38.2-3418.10 – Diabetes Coverage §38.2-3418.11 – Hospice Care §38.2-3418.12 – Hospitalization for Anesthesia & Dental Procedures – Outpatient Services §38.2-3418.16 – Telemedicine services	Medically necessary provider visits and outpatient services – includes coverage for the applicable mandates	N/A	N/A
Emergency Services	N/A for PPOs	Emergency services in the event of a true emergency	N/A	N/A
Hospitalization	§38.2-3418.2 – Bone/Joint Coverage TMJ Procedures §38.2-3418.3 – Hemophilia & Congenital Bleeding Disorders §38.2-3418.4 – Reconstructive Breast Surgery §38.2-3418.6 – Minimum Hospital Stay Mastectomy/Lymph Node Dissection Patients §38.2-3418.8 – Clinical Trials for Cancer §38.2-3418.9 – Minimum Hospital Stay for Hysterectomy §38.2-3418.12 – Hospitalization for Anesthesia & Dental Procedures – Inpatient Services	Medically necessary inpatient services - includes coverage for the applicable mandates	N/A	N/A

Essential Health Benefits
Virginia Benchmark Plan

Benefit Category	Applicable VA Mandate(s)	Benchmark Plan Benefits	Supplemental Benefits Needed	Suggestions/Comments
Maternity and Newborn Care	§38.2-3407.16 – Obstetrical Care – Nondiscriminatory §38.2-3414 – Optional Coverage for Obstetrical Services §38.2-3414.1 – Obstetrical Benefits – Coverage for Postpartum Services §38.2-3411 – Newborn Child Coverage	Coverage for mandated services including the mandated offer for Obstetrical Care	N/A	N/A
Mental Health & Substance Use Disorder, including Behavioral Health Treatment	§38.2-3412.1 – Coverage for Mental Health Services for Individuals and Groups of 25 or less §38.2-3412.1:01 – Coverage for Biologically Based Mental Illness	Coverage for services according to MHPAEA and the Biologically Based Mental Illness mandate	N/A	Per CMS FAQ on Essential Health Benefits Bulletin, it is expected that the benchmark plan will include Mental Health Parity in compliance with MHPAEA.
Prescription Drugs	§38.2-3407.5 – Denial of Certain Prescription Drugs Prohibited §38.2-3407.5:1 – Prescription Contraceptives §38.2-3407.6:1 – Denial of Benefits for Certain Prescription Drugs Prohibited §38.2-3407.9:01 – 3407.9:02 - Prescription Drug Formularies	VA does not mandate coverage of Prescription Drugs but if they are covered, the mandates apply and these are all covered under the benchmark plan	N/A	Rx benefit should means that there must be a PDL and that all mandates are met; however, not require adherence to the exact PDL as the benchmark plan.

Essential Health Benefits
Virginia Benchmark Plan

Benefit Category	Applicable VA Mandate(s)	Benchmark Plan Benefits	Supplemental Benefits Needed	Suggestions/Comments
Rehabilitative & Habilitative Services and Devices	§38.2-3418.5 - Early Intervention Services §38.2-3418.14 – Coverage for Lymphedema §38.2-34.18.15 – Mandated Offer for Coverage of Prosthetic Limbs	Plan covers E/I Services and other mandated benefits. Coverage for Prosthetic Devices goes beyond mandated offer and covers all medically necessary Prosthetic Devices Coverage of Short Term Rehabilitative Therapies subject to visit limits. Plan includes coverage for manipulation therapy such as chiropractic care	E/I Services without the $5,000 cap. Habilitative Services in same manner as Rehabilitative Services covered.	Habilitation is defined by Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier as the process of supplying a person with the means to develop maximum independence in activities of daily living through training or treatment.
Laboratory Services	N/A	Coverage for all medically necessary in and outpatient Lab Services	N/A	N/A
Preventive & Wellness Services and Chronic Disease Management	§38.2-3411.3 – Coverage for Childhood Immunizations §38.2-3411.4 – Coverage for Infant Hearing Screening & Audiological Examinations §38.2-3418.1 – Mammograms §38.2-3418.1.2 – Pap Smears/ Gynecologic Cytology Screening §38.2-3418.7 – PSA Testing & Digital Exams §38.2-3418.7:1 – Colorectal Cancer Screening	All plans cover extensive Preventive Services as required and defined by the ACA. Benchmark plan covers all applicable mandates. Chronic Disease Management – covered in order to be accredited by NCQA and for HEDIS purposes	N/A	Those carriers that are accredited by a nationally recognized quality organization such as NCQA and URAC may meet the Chronic Disease Management requirement in order to obtain and maintain accreditation.
Pediatric Services, including Oral and Vision Care	N/A	Routine Vision Care	Benefits comparable to the FAMIS Smiles for Children program for Oral Care. FEDVP for vision benefits	Smiles for Children benefits for the Oral Care.